New Jersey Division of Developmental Disabilities
Individualized Service Plan

NAME: _____
DATE: _____

A. Consumer Information

Demographics -

DDD ID:
DOB:
Gender:
Primary Language:
Region:
County:

Status:
Waiver Program:
Waiver Status:
Waiver Enrollment Date:
Waiver Waiting List Date:
Support Coordinator:
Waiver Assurance Coordinator (WAC):

Program Information -

Day Program:
Placement Date:
Current Address:
Contact Name:
Phone #:

Employment:
Start Date:
Position:
Contact Name:
Phone #:
Address:

Emergency / Contact Information –

#1
Name:
Relationship
Address:
Home Phone #:
Work Phone #:
Cell Phone #:

#2
Name:
Relationship
Address:
Home Phone #:
Work Phone #:
Cell Phone #:

Guardianship/Co-Guardianship Information –

#1
Name:
Address:
Home Phone #:
Work Phone #:
Cell Phone #:
Date Approved by Court:

#2
Name:
Address:
Home Phone #:
Work Phone #:
Cell Phone #:
Date Approved by Court:

NAME: _____
DATE: _____

Healthcare Contact Information –

Administrative Services Organization (ASO)
ASO Name:
ASO Care Manager:
Contact #:

Managed Care Organization (MCO)
MCO Name:
MCO Care Manager:
Contact #:

Private Insurance:
Contact #:
Member Number:
Group Number:

Medical Contact Information –

Primary Care Physician Name:
Address:
Phone Number:

Preferred Hospital:
Address:
Phone Number:

ICD-9 Primary Diagnosis Code:

ICD-9 Secondary Diagnosis Code:

NAME: _____
DATE: _____

B. Personally Defined Outcomes & Services (Outcome #1 of _____)

Personally Defined Outcome:										
Planning Goal	**Service(s)**	**Procedure Code**	**Reference Assessment Tool** (1)	**No. of Units**	**Unit Type** (2)	**Rate**	**Frequency** (3)	**Duration** (4)	**Provider**	**Payment Source** (5)
1.								to		
2.								to		
3.								to		
4.								to		

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
60 min
Daily

Frequency (3):
Daily
Weekly
Biweekly
Monthly
Quarterly
Annually
Other:

Duration (4):
30 days
60 days
90 days
180 days
1 year
Other:

Payment Source (5):
Medicaid State Plan - MCO
Medicaid State Plan - ASO
Supports Program
CCW
Private Insurance
Medicare
DVRS
Private Pay
Other:

NAME: _____
DATE: _____

B. Personally Defined Outcomes & Services (Outcome #2 of _____)

Personally Defined Outcome:										
Planning Goal	**Service(s)**	**Procedure Code**	**Reference Assessment Tool** (1)	**No. of Units**	**Unit Type** (2)	**Rate**	**Frequency** (3)	**Duration** (4)	**Provider**	**Payment Source** (5)
1.								to		
2.								to		
3.								to		
4.								to		

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
60 min
Daily

Frequency (3):
Daily
Weekly
Biweekly
Monthly
Quarterly
Annually
Other:

Duration (4):
30 days
60 days
90 days
180 days
1 year
Other:

Payment Source (5):
Medicaid State Plan - MCO
Medicaid State Plan - ASO
Supports Program
CCW
Private Insurance
Medicare
DVRS
Private Pay
Other:

NAME: _____
DATE: _____

B. Personally Defined Outcomes & Services (Outcome #3 of _____)

Personally Defined Outcome:										
Planning Goal	**Service(s)**	**Procedure Code**	**Reference Assessment Tool** (1)	**No. of Units**	**Unit Type** (2)	**Rate**	**Frequency** (3)	**Duration** (4)	**Provider**	**Payment Source** (5)
1.								to		
2.								to		
3.								to		
4.								to		

***Reference Assessment Tool (1):**
1. PCPT
2. DDD Assessment Tool
3. Other
4. Other

Units (2):
15 min
30 min
60 min
Daily

Frequency (3):
Daily
Weekly
Biweekly
Monthly
Quarterly
Annually
Other:

Duration (4):
30 days
60 days
90 days
180 days
1 year
Other:

Payment Source (5):
Medicaid State Plan - MCO
Medicaid State Plan - ASO
Supports Program
CCW
Private Insurance
Medicare
DVRS
Private Pay
Other:

C. Employment First Implementation

Please note that New Jersey is an Employment First State, meaning that: "*Competitive employment in the general workforce is the first and preferred post education outcome for people with any type of disability*." In conjunction with this policy, at least one outcome in Section B must be related to employment, the pursuit of employment, or the exploration of employment unless the individual is of retirement age. This outcome should be developed utilizing the **Pathways to Employment** section of the PCPT.

Documentation of Compliance with Employment First Policy:
Please provide the individual's current employment status:

☐ The individual is currently employed.

☐ The individual is unemployed or underemployed and is pursuing employment options.

☐ The individual is not currently pursuing employment at this time.

Please document why employment is not currently being pursued and what needs to change to pursue employment?

_____

_____

D. Religious/Cultural Information

1. Are there any Religious or Cultural preferences that you would like to share with your caregiver/provider? ☐ YES ☐ NO
   If yes, please describe:

   _____

   _____

2. Are there any Religious or Cultural restrictions that you would like share with your caregiver/provider? ☐ YES ☐ NO
   If yes, please describe:

   _____

   _____

E. Health & Safety Information

1. What level of monitoring and support is necessary to reduce the risk of harm to self/others (regardless of the person's living environment)?

	None	Periodic Visual Checks	Within Constant Supervision (Eyesight and/or Hearing)	Within Constant Eyesight AND Physically Near
Inside the Home	0	1	2	3
When Eating	0	1	2	3
When Using the Bathroom	0	1	2	3
Outside in a Familiar Setting	0	1	2	3
Outside in an Unfamiliar Setting	0	1	2	3
Crossing a Street with Traffic	0	1	2	3
Inside a Store or Restaurant	0	1	2	3
Around Other People's Possessions	0	1	2	3
With Strangers	0	1	2	3
With Small Children	0	1	2	3
With People of the Opposite Sex	0	1	2	3
With People of the Same Sex	0	1	2	3
Around Household Pets (dogs, cats, etc.)	0	1	2	3
When Sleeping	0	1	2	3
In Group Leisure Activities	0	1	2	3
Other _____	0	1	2	3

NAME: _____
DATE: _____

2. Please indicate any/all medications that you are currently taking, including any over-the-counter medications, along with prescribed medications that caregivers/providers need to know about:

Name of Medication	Dosage	Frequency	Purpose	Things to note

3. Do you self-medicate? ☐ YES ☐ NO

   If NO, please describe assistance needed and/or method of administering medication _____

   _____

   _____

4. Do you have allergies (Please refer to the DDRT Question 19 j)? ☐ YES ☐ NO

   If yes, what do caregivers/providers need to know to look out for and/or how to treat an allergic reaction:

   _____

   _____

   _____

5. Do you have any special dietary needs/restrictions (Please refer to DDRT Questions 21 i-o)? ☐ YES ☐ NO

   If yes, what do caregivers/providers need to know about these special dietary needs/restrictions:

   _____

   _____

   _____

6. Do you use any adaptive equipment (Please refer to DDRT Question 22 a-i) ? ☐ YES ☐ NO

   If yes, what do caregivers/providers need to know about the use of the adaptive equipment:

   _____

   _____

   _____

7. Please identify any additional important health and safety information that caregivers/providers need to know to keep you healthy and safe not included above (i.e. physical/mental health or behavioral issues, or others.)

   _____

   _____

   _____

F. Emergency Back-Up Plan

The Emergency Back-Up Plan is only required to be completed if the Team deems necessary. The Emergency Back-up Plan must identify specific arrangements necessary to maintain the health and safety of an individual in the event of a breakdown in the routine plan of care. In the event of a life-threatening emergency, call 911**.** *Please identify the order/priority in which these individuals should be called if your Caregiver/Provider does not arrive and you need assistance.*

☐ **Check here if the individual lives in an agency-managed setting with 24-hour access to staff assistance.**
☐ **Check here if the individual uses PERS (Personal Emergency Response System).**

Order/Priority to be Called	Name	Relationship	Primary Contact Number	Backup Contact Number

Other Important Numbers

	Name/Contact Name	Phone Number
Home Care Agency		
Doctor		
Preferred Hospital		
Transportation		
Police		
Fire		
Human Services Helpline		#211
Emergency Response Registration Website		www.registerready.nj.gov
DDD Abuse Hotline		1-800-832-9173
Adult Protective Services (APS)		1-800-792-8820

Special Instructions - Please describe any equipment, environmental factors, service animals, medication, emergency preparedness or other supports that – if not available- would threaten health and safety:

NAME: _____
DATE: _____

G. Authorizations & Signatures

Team Members Present/Participating in developing the Individualized Service Plan

Role	Name	Phone/email	Agency/Region
Individual			
Guardian			
Co-Guardian			
Family/Friends			
Family/Friends			
Support Coordinator			
Division Staff			
Support Broker (If Applicable)			
Other			

Approval of Services Certification:

☐ **I helped develop this Service Plan.**
☐ **I agree with this Service Plan.**
☐ **I had the ability to choose the services in this Service Plan.**
☐ **I had the ability to choose the providers of my services based on available providers.**
☐ **I am aware of my rights & responsibilities as a participant of this program.**

☐ **You may share my Person Centered Planning Tool with *all* providers.**
☐ **You may share my Person Centered Planning Tool with all providers *except*: _____**

Signature_____ ___/___/___
☐ Individual / ☐ Guardian / ☐ Legal Representative — Date

Signature_____ ___/___/___
Support Coordinator — Date

Signature_____ ___/___/___
Date